Molalla Family Eye Care
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PATIENT INFORMATION FORM

PERSONAL INFORMATION

Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Master **Today's date:** _____

Full name: _____ **Date of Birth:** ___/___/___ **Age:** _____ **Sex:** ❑ M ❑ F

Billing address: _____

City: _____ **State:** _____ **Zip:** _____ **E-mail address:** _____

Home phone: ( ) _____ **Work number:** ( ) _____ **Cell phone:** ( ) _____

Primary Care Physician: _____ **PCP phone number:** ( ) _____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Spouse: _____

Ethnicity: *(circle one)* Caucasian Black Asian Latino American Indian Pacific Islander Other _____

Preferred name: _____ **Preferred Language:** _____

Person responsible for bill: _____

Communication preference: ❑ Phone ❑ Text ❑ Email

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Policy Holder's Full Name: _____ **Policy Holder's Date of Birth:** ___/___/___

Patient's relationship to Policy Holder: _____

Insurance Identification Number : _____ **Group Number:** _____

SECONDARY INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Policy Holder's Full Name: _____ **Policy Holder's Date of Birth:** ___/___/___

Patient's relationship to Policy Holder: _____

Insurance Identification Number : _____ **Group Number:** _____

INSURANCE LIABILITY STATEMENT

It is your responsibility to know your insurance company policy, your benefits, and your current eligibility for coverage at the time services are rendered by this office. It is also your responsibility to inform this office if you have changed insurance companies or benefit plans which would affect your current eligibility for coverage. If, for any reason, you are not eligible for insurance coverage at the time of your visit to our office, you will be held financially responsible for any and all services rendered. All insurance co-pays and non-covered charges are due at the time of service.

I HAVE READ THE ABOVE STATEMENT WITH FULL UNDERSTANDING OF ITS TERMS AND CONDITIONS TO WHICH I AM RESPONSIBLE.
I HAVE ALSO BEEN OFFERED A HIPAA POLICY.

PATIENT SIGNATURE: _____ **AUTHORIZED INDIVIDUAL SIGNATURE:** _____

MEDICAL HISTORY QUESTIONNAIRE

This form is critical for the doctor to thoroughly evaluate your vision and health. Please completely fill out both sides. Thank you!

Name:_____ **Date:** ____/____/_____ **Birth date:** ____/____/_____

PERSONAL MEDICAL HISTORY

Last Medical Exam: ____/____/____ **Name of Family Physician** _____

List all major injuries, surgeries and/or hospitalizations: _____

_____

Are you currently being treated for any of the following?

Arthritis:	❑ Yes	❑ No	❑ Family	**Heart Disease :**	❑ Yes	❑ No	❑ Family
Diabetes :	❑ Yes	❑ No	❑ Family	**Stroke:**	❑ Yes	❑ No	❑ Family
High Blood Pressure:	❑ Yes	❑ No	❑ Family	**Other:**	_____		

List any medications you are currently taking (include oral contraceptives, aspirin, etc.) _____

_____

Do you have allergies to medications? ❑ Yes ❑ No **If yes, please list:** _____

_____

If female, are you currently pregnant? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No **If yes, type/amount per week:** _____

Do you drink alcohol? ❑ Yes ❑ No **If yes, type/amount per week:** _____

DISEASE/CONDITION

EYE HISTORY

Blurred Vision	❑ Yes	❑ No	**Dryness**	❑ Yes	❑ No	**Itching**	❑ Yes	❑ No
Burning	❑ Yes	❑ No	**Eye Pain**	❑ Yes	❑ No	**Lazy Eye**	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No	**Flashes of light**	❑ Yes	❑ No	**Light Sensitivity**	❑ Yes	❑ No
Crusting on Eyelid	❑ Yes	❑ No	**Floating dark spots**	❑ Yes	❑ No	**Macular Degeneration**	❑ Yes	❑ No
Decreased Vision	❑ Yes	❑ No	**Foreign Body Sensation**	❑ Yes	❑ No	**Redness**	❑ Yes	❑ No
Discharge	❑ Yes	❑ No	**Glaucoma**	❑ Yes	❑ No	**Retinal Tear/Detachment**	❑ Yes	❑ No
Double Vision	❑ Yes	❑ No	**Halos**	❑ Yes	❑ No	**Sandy/gritty feeling**	❑ Yes	❑ No
Drooping Eyelid	❑ Yes	❑ No						

Past Eye Surgeries? ❑ Yes ❑ No **Type:** _____ **Date:** _____

Past Eye Injuries? ❑ Yes ❑ No **Type:** _____ **Date:** _____

Other: _____

Do you currently wear glasses? ❑ Yes ❑ No **Contact lenses?** ❑ Yes ❑ No ❑ Neither

FAMILY OCULAR HISTORY (i.e. Glaucoma, Macular Degeneration, Diabetic Retinopathy)

RELATIVE	AGE	EYE DISEASE
Father	_____	_____
Mother	_____	_____

REVIEW OF SYSTEMS

Are you currently experiencing problems with any of the following?

SYSTEM			EXPLAIN/MEDICATIONS
• **Sudden weight gain or loss**	❑ Yes	❑ No	_____
• **Chronic fever or chronic fatigue**	❑ Yes	❑ No	_____
• **Heart** *(example: chest pain, angina, irregular heart beat)*	❑ Yes	❑ No	_____
• **Respiratory** *(example: coughing, wheezing, shortness of breath, asthma)*	❑ Yes	❑ No	_____
• **Ear/Nose/Throat** *(example: sore throat, sinus problems, earache, hearing loss)*	❑ Yes	❑ No	_____
• **Gastrointestinal** *(example: abdominal pain, heartburn, bowel problems, vomiting)*	❑ Yes	❑ No	_____
• **Urinary** *(example: pain when urinating, blood in urine)*	❑ Yes	❑ No	_____
• **Hematologic/Lymphatic** *(example: blood disorders, bruising, cuts heal slowly, enlarged glands)*	❑ Yes	❑ No	_____
• **Endocrine** *(example: thyroid problems)*	❑ Yes	❑ No	_____
• **Integumentary** *(example: rashes, dry skin)*	❑ Yes	❑ No	_____
• **Musculoskeletal** *(example: joint pain, stiffness or swelling, muscle pain)*	❑ Yes	❑ No	_____
• **Neurological** *(example: numbness, headache, seizures, paralysis)*	❑ Yes	❑ No	_____
• **Psychiatric** *(example: depression, anxiety, insomnia, confusion)*	❑ Yes	❑ No	_____
• **Allergic/Immunologic** *(example: reaction to food or drugs, allergies, hay fever)*	❑ Yes	❑ No	_____

REVIEWED BY PATIENT AND CHANGES AS INDICATED: **PHYSICIANS SIGNATURE**

Patient's Signature: _____ _____ **Date:** ____/_____/_____

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Patient's Signature: _____ _____ **Date:** ____/_____/_____

Patient's Signature: _____ _____ **Date:** ____/_____/_____

Patient's Signature: _____ _____ **Date:** ____/_____/_____

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